

# WINASAP5010

## Windows Accelerated Submission and Processing

### Montana Medicaid, MHSP, and HMK

February 2012



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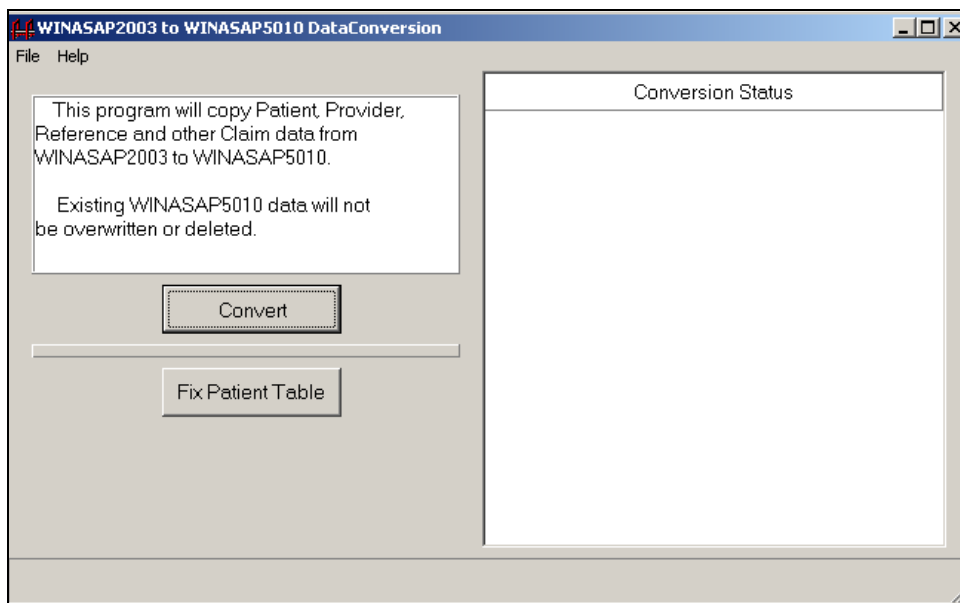
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# Converting a WINASAP2003 Database to a WINASAP5010 Database

WINASAP5010 allows WINASAP2003 users to convert reference table information such as patient and provider records.

To do this, WINASAP5010 must be installed on the same computer as WINASAP2003 because the converter copies the database and converts it to the WINASAP5010 format.

After the conversion, users must open each patient and provider record in WINASAP5010 to enter additional information now required by HIPAA.



1. Click on the Windows Start button.
2. Select Programs.
3. Highlight WINASAP5010.
4. Select Convert WINASAP2003 to WINASAP5010.
5. Click on the Convert button. This copies the WINASAP2003 database and converts it to a usable WINASAP5010 format.
6. Once the conversion is complete, open WINASAP5010 and verify that the data is there. Users must open each patient and provider record and add any additional required information. **Do not use the Restore Database option in WINASAP5010 when converting the WINASAP2003 database. WINASAP5010 will not be able to read the restored database.**

# Using the Converted WINASAP2003 Database in WINASAP5010

WINASAP5010 and WINASAP2003 (which uses the previous 4010 standard) have very different database structures in terms of new fields, increased length, and deleted field qualifier values. Before creating and sending claims in WINASAP5010, users must review the following to ensure that there would be no errors using WINASAP5010 and no compliance errors when the claims have been sent to EDI:

- **Trading Partner Information.** The information from WINASAP2003 in this window was designed **not to be copied** into WINASAP5010 to ensure that users would not accidentally transmit WINASAP2003 files to the WINASAP5010 system. Complete the necessary fields and click on the Save button to ensure that the values entered are 5010-compliant.
- **Provider Data.** There are several changes and corrections done in this window. The biggest changes are in the Secondary Identification Type (Provider Tax Identification Number) which is required and needs to be filled out first to use that provider. Some identification types were deleted and show as blanks in 5010. Delete their respective identification number or update them with their corresponding new identification types. Click on the Save button to ensure the values entered are 5010-compliant.
- **Patient Data.** New fields (e.g., property and casualty information) can be seen in both the Patient Data and the Insured's Data tabs. These fields are situational and must be left blank. Additionally, there is a new button in the Insured's Data tab (Payer Secondary ID). This information is also situational. Click on the Save button to ensure that the values entered are 5010-compliant.
- **Claims Data – Dental Claim, Institutional Claim, Nursing Facility Claim, Nursing Facility Template, and Professional Claim.** Several fields and pull-down items were deleted in WINASAP5010. **It is very important that users do not copy claims that were converted from WINASAP2003 to WINASAP5010.** The formats are very different, and any converted claim that is copied will cause claims to reject. However, users can copy any claim that is originally created in WINASAP5010 for submission.

# General Information

## WINASAP

- Windows Accelerated Submission and Processing (WINASAP5010) is Windows-based; Windows 98, NT, 2000, XP, Vista, and Windows 7 software application developed by EDI Gateway. WINASAP5010 allows users to submit claim data electronically from their personal computer to EDI Gateway.
- WINASAP does not require an Internet connection in order to transmit claims. The basic requirements are a PC running Windows 98 Second Edition or higher and a standard analog (non-digital) phone line. If possible, users should not be connected to the Internet while transmitting WINASAP claims.
- Software updates can be downloaded from [www.acs-gcro.com](http://www.acs-gcro.com).
- WINASAP is not case-sensitive.
- Most Windows-based keyboard commands are available in WINASAP: Tab key moves cursor from field to field; Shift + Tab moves cursor back field-to-field; Control + C is a copy command; Control + V is a paste command.
- The F5 key enters the current date in any date field.
- WINASAP does not allow users to save an incomplete provider, patient, or claim entry. A claim must be placed in Hold status to save an incomplete entry.
- It is recommended that the WINASAP database is periodically backed up to prevent loss of data, and for the ability to recall data.
- If users are running WINASAP on a Macintosh (Mac), they will need a Windows parallel because WINASAP is Windows-based and will not operate solely on a Mac.
- If running Windows Vista, to access WINASAP, right-click on the WINASAP icon and select Run as Administrator to allow access.

## Claims

- To electronically submit claim data to EDI Gateway, users must be enrolled as either a provider or an authorized billing agent for actively enrolled providers. This varies by payer. Users should contact their Medicaid office for more information.
- If a user cancels or exits a claim prior to saving, the claim will be lost. WINASAP does not automatically prompt a user to save the claim.
- Users are recommended to keep claim lists as short as possible by deleting old claims on a regular basis. Maintaining large claim lists will adversely affect software performance and increase error messages.
- A hard copy of an individual claim can be printed by selecting File/Print while the claim is open.

## Enrollment/Registration

- During the enrollment process, users must complete an EDI Gateway enrollment form and sign an EDI Trading Partner Agreement if they wish to submit claims electronically. As part of the EDI registration process, EDI Gateway will assign a Trading Partner ID, User Name, and User ID.
- For EDI registration and technical support, users should contact their EDI Support Unit. Users may obtain the EDI enrollment form from [www.acs-gcro.com](http://www.acs-gcro.com).

## Provider/Patient Information

- Provider and patient information must be entered in the reference database prior to incorporating it into the electronic claim. Procedure, diagnosis, and revenue codes can be entered into reference databases, but they do not have to be entered prior to building a claim. These codes can be entered directly into the Claim screen.
- Generally, all required fields are underlined on the Entry screens; however, a particular claim may require additional information such as a prior authorization number or Passport referral number. This guide identifies all required fields.

## Contact

- Questions regarding technical issues pertaining to WINASAP, electronic claims submission, and enrollment should be directed to the EDI call center at 1-800-987-6719.
- Other questions should be directed to Provider Relations at 1-800-624-3958 or 406-442-1837.

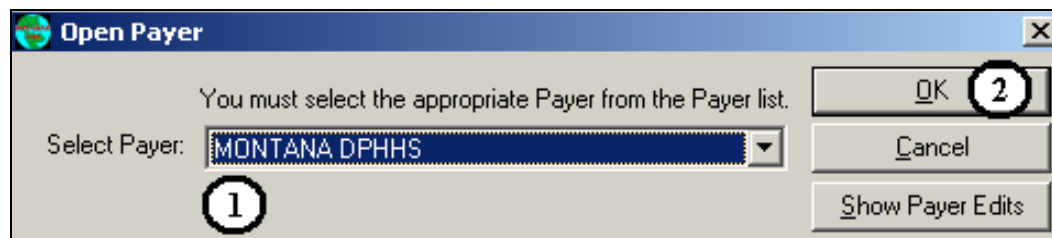


# Initial Setup

1. Enter the default password “asap” (not case-sensitive).
2. Click on OK.

At initial setup, WINASAP prompts users to Select Payer.

1. On the pull-down menu, select Montana DPHHS.
2. Click on OK.

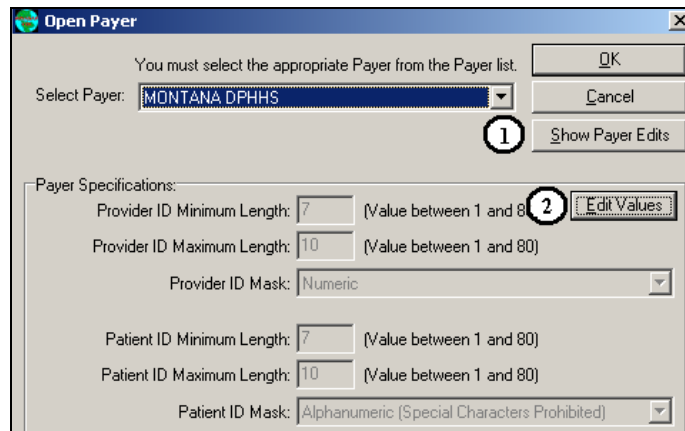


This is a one-time-only setup. Subsequently, each time WINASAP is opened, Montana DPHHS will be set as the payer.

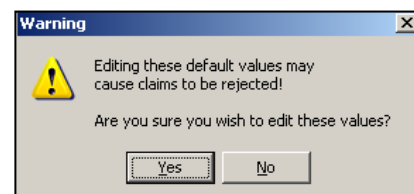
## Setting Patient ID Character Length

This step must be completed before patients can be entered in the patient list with either a SSN or a card number.

Under File, select Open Payer.



1. Click on the Show Payer Edits button.
2. Click on Edit Values. A warning appears; click Yes.
3. Enter “7” in the Patient ID Minimum Length field.
4. Click on OK.



# Trading Partner/Submitter Setup

The communications settings for Fields 1, 2, 10, 11, and 12 below can be found on the Welcome Letter sent by EDI. Under the File pull-down menu at the top of the screen, select Trading Partner.

The screenshot shows a 'Trading Partner Information' dialog box with the following sections and fields:

- Trading Partner Identification:**
  - Primary Identification: 7777777 (1)
  - Secondary Identification: 7777777 (2)
- Trading Partner Name:**
  - Entity Type: Non-Person (3)
  - Organization Name: Provider Name (4)
  - Last Name: (5)
  - First Name: (6)
  - Middle Name: (7)
- Contact Information:**
  - Contact Name: Contact Name (8)
  - Telephone #: (000)000-0000 Ext. (9)
  - FAX #: ( ) - (10)
  - Email: (11)
- Additional Contact Information:**
  - Contact Name: Additional Contact Name (12)
  - Telephone #: (000)000-0000 Ext. (13)
  - Fax #: ( ) - (14)
  - Email: (15)
- WINASAP5010 Communications:**
  - Host Telephone #: 18003344650 (16)
  - User ID #: User ID (17)
  - User Name: User Name (18)
- Buttons:** Save (19), Cancel (20)

1. Under Primary Identification, users enter their 7-digit Trading Partner/Submitter ID Number assigned by EDI. (Hint: It always begins with 7.)
2. Under Secondary Identification, users enter their 7-digit Trading Partner/Submitter ID Number assigned by EDI. (Hint: It always begins with 7.)
3. On the pull-down menu, select Entity Type, either Person or Non-Person.
4. Enter Organization Name. If Person is selected under Entity Type, enter last name and first name in the appropriate fields. Middle name is optional.
5. Enter the Contact Name (name of billing person).
6. Enter the Telephone Number.
7. Enter the Fax Number (optional).
8. Enter the E-mail address (optional).
9. Enter Additional (secondary) Contact Information (optional).
10. Enter the Host Telephone Number (the 800-number supplied by EDI). If users need to dial a 9 or other number to connect to an outside line, they enter that number followed by a comma (9,) before dialing the rest of the number. The Host Telephone number must not contain any dashes.
11. Enter the User ID # (assigned by EDI). Sometimes referred to as Password.
12. Enter the User Name (assigned by EDI). Sometimes referred to as Login ID.
13. When completed, click on Save.

# Entering Taxonomy Codes

Under Reference, select Taxonomy Code. This opens the Taxonomy Code List. Click on Add to add a taxonomy code to the list.

The screenshot shows a 'Taxonomy Code List' window. Inside, there's a 'Taxonomy Code Data' section. It has two input fields: 'Taxonomy Code' (containing '193400000X') and 'Taxonomy Code Description' (containing 'Group Taxonomy'). At the bottom right, there are 'Save' and 'Cancel' buttons. Numbered circles 1, 2, and 3 are placed next to the first field, the second field, and the 'Save' button respectively.

1. Enter the 10-digit alphanumeric Taxonomy Code.
2. Enter a brief description of the Taxonomy Code.
3. Click on Save.
4. A System Message appears. Click on Yes to save the atypical provider number. Once a Taxonomy Code is added, it is available for selection when entering provider data (see next page).

The screenshot shows a 'System Message' dialog box with a yellow warning icon. The text inside says: 'You did not set any value in the NPI Number. Are you sure the provider is not a mandated HIPAA National Provider Identifier (NPI)?'. At the bottom, there are 'Yes' and 'No' buttons.

# Entering Provider Data (NPI)

Under the Reference pull-down menu at the top of the screen, select Provider. This opens the Provider list. Click on Add to add a provider to the list.

The screenshot shows a web-based form titled "Provider Data" with a tabbed interface. The "Provider Data" tab is active. The form is divided into several sections: "Provider Identification" (NPI Number, Provider Taxonomy Code), "Provider Name" (Entity Type, Organization Name, Last Name, First Name, Middle Name, Suffix), "Provider Address" (Address, Address (cont'd), City, State, Zip Code), "Provider Tax Identification Number" (ID Type, ID Number), "Contact Information" (Contact Name, Telephone #, Ext., Fax #, Email), and "Additional Contact Information" (Contact Name, Telephone #, Ext., Fax #, Email). At the bottom are "Next Page", "Save", and "Cancel" buttons. Numbered callouts 1 through 13 point to specific fields and buttons: 1. NPI Number field; 2. Provider Taxonomy Code pull-down menu; 3. Entity Type pull-down menu; 4. Organization Name field; 5. Address field; 6. ID Type pull-down menu; 7. ID Number field; 8. Contact Name field; 9. Telephone # field; 10. Fax # field; 11. Email field; 12. Additional Contact Information Telephone # field; 13. Save button.

1. Enter the provider's NPI.
2. In the pull-down menu select the correct provider taxonomy code from the Taxonomy Code Data pull-down menu.
3. On the pull-down menu, select Entity Type, either Person or Non-Person.
4. Enter Organization Name. If Person is selected under Entity Type, enter the Last Name and First Name in the appropriate fields. Middle Name and Suffix are optional.
5. Enter Provider Address (must be physical address, no post office boxes), including City, State, and ZIP code (ZIP + 4).
6. Select ID Type for Provider Tax Identification Number.
7. Enter the provider's Tax ID Number.
8. Enter the Contact Name (name of billing person).
9. Enter the contact Telephone Number.
10. Enter the contact Fax Number (optional).
11. Enter the contact E-mail address (optional).
12. Enter Additional Contact Information (optional).
13. Click on Save. The provider now appears in the provider list. To add additional provider numbers, follow the same instructions.

# Entering Provider Data (Atypical)

Under the Reference pull-down menu at the top of the screen, select Provider. This opens the Provider List. Click on Add to add a provider to the list.

The screenshot shows a software window titled "Provider Data" with a tabbed interface. The "Provider Data" tab is active, showing a form with several sections: "Provider Identification" (NPI Number, Provider Taxonomy Code), "Provider Name" (Entity Type, Organization Name, Last Name, First Name, Middle Name, Suffix), "Provider Address" (Address, City, State, Zip Code, with a note "Billing and Service Facility Provider Zip MUST be 9 digits"), "Provider Tax Identification Number" (ID Type, ID Number), "Contact Information" (Contact Name, Telephone #, Ext., Fax #, Email), and "Additional Contact Information" (Contact Name, Telephone #, Ext., Fax #, Email). Numbered callouts 1 through 11 are placed over the form: 1 points to the Entity Type dropdown; 2 points to the Organization Name field; 3 points to the Address field; 4 points to the ID Type dropdown; 5 points to the ID Number field; 6 points to the Contact Name field; 7 points to the Telephone # field; 8 points to the Fax # field; 9 points to the Email field; 10 points to the Additional Contact Information section; and 11 points to the "Next Page" button at the bottom right.

1. On the pull-down menu, select Entity Type, either Person or Non-Person.
2. Enter Organization Name. If Person is selected under Entity Type, enter the Last Name and First Name in the appropriate fields. Middle Name and Suffix are optional.
3. Enter the Provider Address, including City, State, and ZIP Code (ZIP + 4).
4. Select ID Type for Provider Tax Identification Number.
5. Enter the provider's Tax ID Number.
6. Enter the Contact Name (name of billing person).
7. Enter contact Telephone Number.
8. Enter contact Fax Number (optional).
9. Enter contact E-mail address (optional).
10. Enter Additional Contact Information (optional).
11. Click on Next Page.

## Secondary Identification

The screenshot shows a software window titled "Provider Data" with a tab labeled "Secondary Identification". The window contains several form panels for adding identification numbers. The first panel is pre-filled with "Provider Commercial Number" for Identification Type and "#####" for Identification Number. Numbered callouts 1, 2, and 3 point to the Identification Type dropdown, the Identification Number field, and the Save button respectively.

1. Under Identification Type, select Provider Commercial Number.

2. In the Identification Number field, enter the provider's 7-digit Montana Medicaid Provider Number.

3. Click on Save. The provider now appears in the provider list. To add additional provider numbers, follow the same instructions.

# Entering Patient Data

Under the Reference pull-down menu at the top of the screen, select Patient. This opens the Patient List. Click on Add to add a patient to the list.

## Patient Data

The screenshot shows a software window titled "Patient Data" with a tabbed interface. The "Patient Data" tab is active. The form is divided into several sections: "Patient Identification" with fields for "Patient ID #" (1) and "Patient Account #" (2); "Patient Name and Demographic Information" with fields for "Last Name" (3), "First Name", "Middle Name/Initial", "Suffix", "Date of Birth" (4), "Date of Death", "Weight", "Sex" (5), and a "Medicare Recipient?" checkbox; "Property and Casualty Information" with fields for "Contact Name", "Telephone #", "Ext.", "Property and Casualty Claim #", "Property and Casualty Patient Code", and "Property and Casualty Patient Identifier"; and "Patient Address Information" with fields for "Address" (6), "Address (cont.)", "City", "State", and "Zip". At the bottom, there is a "7" icon and three buttons: "Insurance", "Save", and "Cancel".

1. Enter the Patient ID Number. This is a 7- or 9-digit number, usually the client's Social Security number.
2. Enter the Patient Account Number. If users do not assign patient account numbers, enter the Client ID number. **Do not leave blank.**
3. Enter the patient's last name and first name in appropriate fields. Middle Name/Initial and Suffix are optional.
4. Enter patient's Date of Birth (mm/dd/ccyy).
5. On the pull-down menu, select the patient's Sex.
6. Enter patient's address, including City, State, and ZIP Code (ZIP + 4). Telephone Number is not required.
7. Click on Insurance to go to the second screen. If the error for invalid length of the Patient ID appears, the length of an acceptable Patient ID can be modified under File/Payer/Show Payer Edits.

## Insured's Data

**Patient Data**

Patient Data | Insured's Data

**Insured's Information**

Patient ID #: 1234567 Insured's SSN:

Patient Relationship to Insured: 1 Insured's Primary ID:

Entity Type: Insured's Group or Plan Name:

Organization Name: Insured's Group or Policy #:

Last Name: Insured's Address:

First Name: Insured's Address (cont):

Middle Name/Initial: Insured's City:

Suffix: Insured's State: Insured's Zip Code:

Date of Birth: / / Sex:

**Property and Casualty Information**

Contact Name: Telephone #: ( ) - Ext. Property and Casual Claim #:

**Payer Information**

Payer Name: MONTANA DPHHS Payer Primary ID: 77039

Payer Address: Payer Responsibility Sequence Code: 2

Address (cont): Insurance Type:

City: Payer Secondary ID:

State: Zip:

Patient Data 3 Save Cancel

1. In the pull-down menu, select Self. This automatically populates the appropriate fields in the upper section of the screen. DPHHS clients are **always** Self.
2. In the Payer Responsibility Sequence Code pull-down menu, indicate whether Medicaid is primary, secondary, or tertiary.
3. Click on Save. The patient now appears on the patient list and will be available when building a claim. Add additional patients using these same instructions.

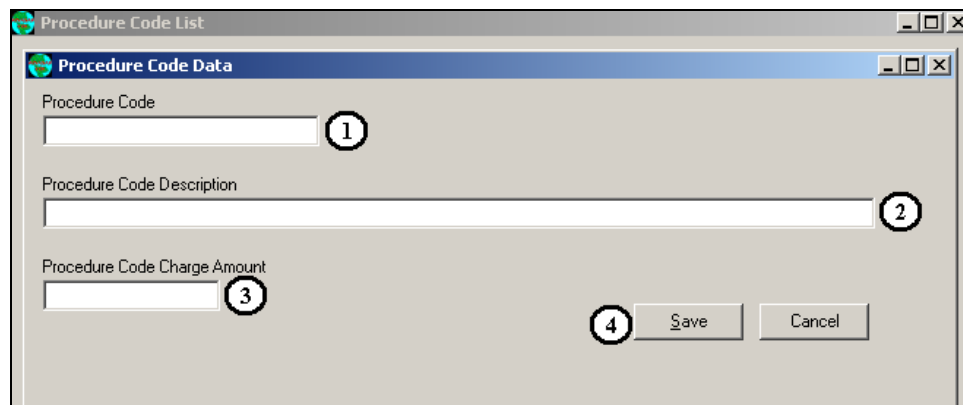


# Entering Procedure, Diagnosis, and Revenue Codes

Unlike provider and patient data, procedure codes, diagnosis codes, and revenue codes do not have to be entered into the reference databases prior to incorporating them into a claim. These codes can be entered directly into the Claim Entry screen.

Under the Reference pull-down menu at the top of the screen, select Procedure Code. This opens the Procedure Code List. Click on Add to add a procedure code to the list.

## Procedure Code Data



1. Enter the HCPCS code. Do not add code modifiers here.
2. Enter a description of the procedure/service.
3. Enter the charge amount with 2-digit decimal. If the charge is variable, do not enter the charge amount. Charges can be entered manually in the Claim Entry screen.
4. Click on Save.

The procedure code now appears on the Procedure List. Add additional procedure codes using the same instructions.

Under the Reference pull-down menu at the top of the screen, select Diagnosis. This opens the Diagnosis Code List. Click on Add to add a diagnosis code to the list. Enter ICD-9. ICD-10 Codes will not be used until October 2013.

## Diagnosis Code Data

The screenshot shows a window titled 'Diagnosis ICD-9-CM Code List'. Inside is a sub-window titled 'Diagnosis Code Data'. It contains two text input fields. The first is labeled 'Diagnosis Code' and has a circled '1' next to it. The second is labeled 'Diagnosis Code Description' and has a circled '2' next to it. At the bottom right of the sub-window are two buttons: 'Save' and 'Cancel'.

1. Enter the Diagnosis Code. Users will not see the decimal, but it is recognized to follow after the third digit (e.g., 12310 = 123.10).
2. Enter a Diagnosis Code Description.
3. Click on Save. The diagnosis code now appears on the Diagnosis Code List. Add additional diagnosis codes using the same instructions.

Under the Reference pull-down menu at top of screen, select Revenue Code. This opens the Revenue Code List. Click on Add to add a revenue code to the list.

## Revenue Code Data

The screenshot shows a window titled 'Revenue Code List'. Inside is a sub-window titled 'Revenue Code Data'. It contains three text input fields. The first is labeled 'Revenue Code' and has a circled '1' next to it. The second is labeled 'Revenue Code Description' and has a circled '2' next to it. The third is labeled 'Revenue Code Charge Amount' and has a circled '3' next to it. At the bottom right of the sub-window are two buttons: 'Save' and 'Cancel', with a circled '4' next to the 'Save' button.

1. Enter the Revenue Code.
2. Enter the Revenue Code Description.
3. Enter the Revenue Code Charge Amount with a 2-digit decimal. If the charge is variable, do not enter the charge amount. Charges can be entered manually in the Claim Entry screen.
4. Click on Save. The revenue code now appears on the Revenue Code List. Add additional revenue codes using the same instructions.

# Creating a Professional Claim (CMS-1500 Format)

Under the Claims pull-down menu at the top of the screen, select Professional. This opens the Professional Claim List. Click on Add to add a professional claim to the list.

## Claim Data

The screenshot shows the 'Professional Claim Data' window with the following fields and callouts:

- 1**: Bill Date (mm/dd/ccyy) field.
- 2**: Patient ID pull-down menu.
- 3**: Billing Provider pull-down menu.
- 4**: Signature on File radio buttons (No/Yes).
- 5**: Diagnosis Type Code pull-down menu.
- 6**: Principal Diagnosis pull-down menu.
- 7**: Place of Service pull-down menu.
- 8**: Claim Frequency Type Code pull-down menu.
- 9**: Next Page button.

1. Enter the Bill Date (mm/dd/ccyy). Press the F5 key to enter the current date.
2. Use the pull-down menu to access the Patient List; select Patient ID Number.
3. Use the pull-down menu to access the Provider List; select the Billing Provider ID Number.
4. In the Signature on File field, choose the Yes option.
5. Select Diagnosis Type Code (ICD-9). ICD-10 will not be used until October 2013.
6. Enter the diagnosis code by keying in the diagnosis code or accessing the Diagnosis Code List using the pull-down menu. For diagnosis codes with fourth or fifth digits, the decimal point is not visible, but WINASAP recognizes it between the third and fourth digits. To enter additional diagnosis codes, click Other Diagnosis Codes.
7. Under the pull-down menu, select the Place of Service.
8. Under the pull-down menu, **always** select 1: Original (Admit thru Discharge Claim).
9. Click on Next Page.

Claim Status automatically defaults to Keyed. This status changes once the claim is successfully submitted. If billing a Rendering Provider, add the Provider Data in the Provider List following the previously stated instructions and select the appropriate Provider from the pull-down menu.

## Claim Codes

The screenshot shows the 'Professional Claim Data' window with the 'Claim Codes' tab selected. The form is divided into several sections: 'Claim Codes', 'Claim Indicators', 'Claim Amounts', and 'Claim Numbers'. Numbered callouts (1-8) point to specific fields: 1. Medicare Assignment Code (pull-down menu); 2. Release of Information Code (pull-down menu); 3. Special Program Indicator Code (pull-down menu); 4. Claim Filing Indicator (pull-down menu); 5. Benefits Assignment Certification Indicator (pull-down menu); 6. Referral Number (text field); 7. Prior Authorization (text field); 8. Next Page button.

1. If known, select the appropriate Medicare Assignment Code from the pull-down menu. If unknown, select Not Assigned. This is the recommended default. **This is a HIPAA-required field.**
2. Under the pull-down menu, users select the entry that best reflects their office protocol regarding release of information. **This is a HIPAA-required field.**
3. (Optional) To indicate EPSDT at the claim level, select EPSDT on the pull-down menu.
4. Under the pull-down menu, **always** select Medicaid.
5. From the pull-down menu, select Yes for the Benefits Assignment Certification Indicator.
6. If the claim requires a Passport Referral Number, enter it here.
7. If the claim requires a Prior Authorization Number, enter it here.
8. Click on Next Page.

## Claim Information

In most cases, there are no required fields on this screen; however, there are two fields that *may* be required for the claim.

Professional Claim Data

Claim Data | Claim Codes | Claim Information | Claim Line Items

Claim Information

Additional Claim Level Information

Ambulance Transport Info	Other Subscriber Info ①
Claim Note	Spinal Manipulation Info
Claim Price/Reprice Information	Supplemental Info ②
Contract Info	Related Causes Info
EPSDT Info	Service Facility Info
File Info	Vision Info
Miscellaneous Dates	

③ Next Page Previous Page Save Cancel

Other Subscriber Info (1) can be entered if the patient has additional insurance (TPL) that pays primary to Medicaid.

Supplemental Info (2) can be used to indicate that a paperwork attachment to the electronic claim has been sent by mail, or to reference a blanket denial letter on file in the Third Party Liability Unit.

Specialized instructions for these fields can be found in Appendices A, B, and C.

1. To enter TPL information, click on Other Subscriber Info.
2. To enter paperwork attachment information, click on Supplemental Info.
3. Click on Next Page.

## Claim Line Items

The number in the upper right corner of this screen indicates which line is being entered. As each line is added, this number changes. The total claim charges appear in the box on the lower left. WINASAP can accommodate up to 39 line items in a single claim.

The screenshot shows the 'Professional Claim Data' window with the 'Claim Line Items' tab selected. The interface includes several input fields and a table for entering claim line items. Numbered callouts indicate the following elements:

- 1: Service Date(s) input field.
- 2: Service Qual pull-down menu.
- 3: Proc Code input field.
- 4: Procedure Modifiers pull-down menu.
- 5: Unit Code pull-down menu.
- 6: Units input field.
- 7: Charges input field.
- 8: Diagnosis Code Pointers input field.
- 9: Miscellaneous Indicators button in the 'Additional Line Item Information' section.
- 10: Add line item button.
- 11: Save button at the bottom right.

The 'Additional Line Item Information' section contains a grid of buttons for various categories: Attachment Info, File Info, Medical Equipment Info, Miscellaneous Providers, Ambulance Transport Info, Form ID Info, Miscellaneous Amounts, Purchased Service Info, Contract Info, Line Adjudication Info, Miscellaneous Dates, Service Facility Info, DMERC Condition Info, Line Item Notes, Miscellaneous Indicators, Supplemental Info, Drug Information, Line Price/Reprice Info, Miscellaneous Numbers, and Test Results.

The 'Claim Line Items' table has columns for #, Service Dates (From, To), Proc Code, Modifiers (1, 2, 3, 4), Units of Service, and Charges. The 'Total Claim Charges' box is located on the right side of the table.

1. Enter the Service Dates (mm/dd/ccyy). If a single date of service, enter the date in both fields.
2. Under the pull-down menu, **always** select HCPCS.
3. Enter the HCPCS procedure/service code. Either key in the code or access the Procedure Code list using the pull-down menu.
4. Enter up to four Procedure Modifiers.
5. Under the pull-down menu, **always** select Unit.
6. Enter the number of units being billed.
7. Enter the Charges. If the procedure code was previously entered into the Reference database with the corresponding per unit charge, WINASAP automatically calculates the charge.
8. Enter the Diagnosis Code Pointers.
9. To indicate EPSDT, Family Planning, or both, click on Miscellaneous Indicators. Check Yes under Other Indicators/Was the service the result of a screening referral? To indicate Family Planning, select Yes under Family Planning. For both, select Yes for both. (The pregnancy indicator is on the Claim Codes screen under Claim Indicators).
10. Click on Add Line Item. Repeat steps above to add additional lines.
11. When all line items have been entered, click on Save.

# Creating an Institutional Claim (UB-04 Format)

Under the Claims pull-down menu at the top of the screen, select Institutional. This opens the Institutional Claim List. Click on Add to add a new claim to the list.

## Claim Data

The screenshot shows the 'Institutional Claim Data' form with the following fields and callouts:

- 1**: Bill Date (mm/dd/ccyy) with a calendar icon.
- 2**: Patient ID pull-down menu.
- 3**: Billing Provider pull-down menu.
- 4**: Admission Date (mm/dd/ccyy) with a calendar icon.
- 5**: Admission Type pull-down menu.
- 6**: Discharge Status pull-down menu.
- 7**: Statement Coverage Period From date (mm/dd/ccyy) with a calendar icon.
- 8**: Prior Authorization # text field.
- 9**: Type of Bill pull-down menu.
- 10**: Next Page button.

Other fields include: User Batch #, Claim Number, Claim Status (Keyed), Transaction Type (Chargeable), Patient Account #, Date of Birth, Sex, Last Name, First Name, Middle Name/Initial, Pay-to Address, Service Facility Location, Tax ID, Taxonomy Code, Attending Provider, Operating Physician, Other Operating Physician, Rendering Provider, Referring Provider, Pay To Plan, Referral #, Auto Accident State, Medical Record #, Repricer Received Date.

\*Claim Status automatically defaults to Keyed. This status changes once the claim is successfully submitted.

1. Enter the Bill Date (mm/dd/ccyy). Press the F5 key to enter the current date.
2. Use the pull-down menu to access the Patient list; select the Patient ID Number.
3. Use the pull-down menu to access the Provider list; select the Billing Provider ID Number.
4. Enter the Admission Date.
5. Enter the Admission Type.
6. Enter the Discharge Status. Refer to the UB-04 Instructions for valid status codes.
7. Enter the Statement Coverage Period dates.
8. If required, enter the Prior Authorization Number.
9. Enter the Type of Bill.
10. Click on Next Page.

## Claim Codes

The screenshot shows the 'Institutional Claim Data' window with the 'Claim Codes' tab selected. The form is divided into several sections: Procedure Codes, Diagnosis Codes, Additional Claim Codes, and Additional Claim Information. Numbered callouts (1-11) point to specific fields and buttons: 1 points to the Principal Diagnosis Code Qualifier dropdown; 2 points to the Principal Diagnosis Code field; 3 points to the Admitting Diagnosis Code Qualifier dropdown; 4 points to the Admitting Diagnosis Code field; 5 points to the Assignment or Plan Participation Code dropdown; 6 points to the Release of Information Code dropdown; 7 points to the Claim Filing Indicator Code dropdown; 8 points to the Assignment of Benefits Indicator dropdown; 9 points to the 'Other Subscriber Info' button; 10 points to the 'Supplemental Info' button; and 11 points to the 'Next Page' button. The 'Patient Responsibility Amount' field has an asterisk (\*) next to it.

\* Personal Resource Amounts can be entered in Patient Responsibility Amount.

1. Select the Principal Diagnosis Code Qualifier from the pull-down menu.
2. Enter the Principal Diagnosis Code either manually or from the pull-down menu (if previously saved in WINASAP5010). For diagnosis codes with fourth or fifth digits, the decimal point will not be visible; however, WINASAP will recognize that it lies between the third and fourth digits.
3. Select the Admitting Diagnosis Code Qualifier from the pull-down menu.
4. Enter the Admitting Diagnosis Code either from the pull-down menu (if previously saved in WINASAP5010) or enter it manually (for diagnosis codes with fourth or fifth digits, the decimal point will not be visible; however, WINASAP recognizes that it lies between the third and fourth digits).
5. If known, select the appropriate Assignment or Plan Participation Code from the pull-down menu. If unknown, select Not Assigned. This is the recommended default.
6. Under the pull-down menu, users select the entry that best reflects their office protocol regarding Release of Information.
7. Under the Claim Filing Indicator Code pull-down menu, **always** select Medicaid.
8. Under the Assignment of Benefits Indicator, select Yes from the pull-down menu.
9. If there is TPL that pays primary to Medicaid, click on Other Subscriber Info to enter the TPL information (See Appendix A).
10. Click on Supplemental Info to indicate that a paperwork attachment to the electronic claim has been sent by mail or fax, or to reference a blanket denial letter on file with the Third Party Liability Unit (See Appendix B).
11. Click on Next Page.



## Claim Line Items

The screenshot shows the 'Institutional Claim Data' window with the 'Claim Line Items' tab selected. The form is designed for entering detailed information for each line item on a claim. Numbered callouts 1 through 10 highlight specific fields: 1. Service Line Revenue Code, 2. Product / Service ID Qualifier, 3. Procedure Code, 4. Procedure Modifiers, 5. Line Item Charge Amount, 6. Unit or Basis for Measurement Code, 7. Service Units Count, 8. Service Date(s), 9. Add line item button, and 10. Save button. Below the main form is a table for listing multiple line items, and a 'Total Claim Charges' field.

#	Service Dates From	Service Dates To	Revenue Code	HCPCS Code	Modifiers 1	Modifiers 2	Modifiers 3	Modifiers 4	Service Units Count	Line Item Charge Amount
1										
2										
3										
4										
5										

1. Enter the Service Line Revenue Code or select it from the pull-down menu if it has been previously saved in WINASAP.
2. Select HCPCS from the Product/Service ID Qualifier pull-down menu.
3. Enter the Procedure Code or select it from the pull-down menu if it has been previously saved in WINASAP.
4. Enter up to four Procedure Modifiers.
5. Enter the Line Item Charge Amount.
6. Under the Unit or Basis of Measurement Code pull-down menu, **always** select Unit.
7. In the Service Units Count field, enter the number of units being billed.
8. Enter the Service Dates.
9. Click on Add Line Item. Repeat these steps for additional line charges.
10. When all the lines have been entered, click on Save.

The claim now appears in the Institutional Claim List window. Add additional claims using these same instructions.

# Creating a Dental Claim

Under the Claims pull-down menu at the top of the screen, select Dental. This opens the Dental Claim List. Click on Add to add a dental claim to the list.

## Claim Data

The screenshot shows the 'Dental Claim Data' window with the following fields and callouts:

- 1**: Bill Date (mm/dd/ccyy)
- 2**: Patient ID (pull-down menu)
- 3**: Billing Provider (pull-down menu)
- 4**: Signature on File (radio buttons: No, Yes)
- 5**: Place of Service (pull-down menu)
- 6**: Claim Frequency Type Code (pull-down menu)
- 7**: Principal Diagnosis (pull-down menu)
- 8**: Principal diagnosis code (manual entry or pull-down menu)
- 9**: Next Page button

1. Enter the Bill Date (mm/dd/ccyy). Press the F5 key to enter the current date.
2. Use the pull-down menu to access the Patient list; select Patient ID Number.
3. Use the pull-down menu to access the Provider list; select the Billing Provider ID Number.
4. In the Signature on File field, choose Yes.
5. Under the Place of Service pull-down menu, select the place of service.
6. Under the Claim Frequency Type Code pull-down menu, **always** select 1: Original (Admit thru Discharge Claim).
7. Under the Principal Diagnosis pull-down menu, select the principal diagnosis code qualifier.
8. Enter the principal diagnosis code either manually or from the pull-down menu if previously saved in WINASAP5010). For diagnosis codes with fourth or fifth digits, the decimal point will not be visible; however, WINASAP recognizes that is lies between the third and fourth digits.
9. Click on Next Page.

## Claim Information

The screenshot shows the 'Dental Claim Data' application window with the 'Claim Information' tab selected. The form includes the following fields and sections:

- Release of Information Code:** A pull-down menu highlighted with a circled 1.
- Special Program Indicator:** A pull-down menu highlighted with a circled 2.
- Delay Reason Code:** A pull-down menu.
- Claim Filing Indicator Code:** A pull-down menu highlighted with a circled 3.
- Accident Date:** A date field with a calendar icon.
- Replacer Received Date:** A date field with a calendar icon.
- Date of Service:** A date field with a calendar icon.
- Patient Amount Paid:** A text input field highlighted with a circled 4.
- Service Authorization Exception Code:** A pull-down menu.
- Predetermination of Benefits Indicator:** A checkbox.
- Claim Original Reference #:** A text input field.
- Benefits Assignment Certification Indicator:** A pull-down menu highlighted with a circled 5.
- Additional Claim Level Information:** A grid of buttons:
 

Related Causes Info	Service Facility Info	Predetermination Identification	Contract Info
Claim Notes	Supplemental Info	Tooth Status Info	Referral #
Prior Authorization	Other Subscriber Info	Orthodontic Info	File Info

 The 'Other Subscriber Info' button is highlighted with a circled 6.
- Buttons at the bottom:** 'Repriced Claim', 'Adjusted Repriced Claim', 'Claim Pricing/Repricing', 'Next Page' (highlighted with a circled 7), 'Previous Page', 'Save', and 'Cancel'.

1. **This is a HIPAA-required field.** Under the pull-down menu, users select the entry that best reflects their office protocol regarding release of information.
2. This is optional. To indicate EPSDT at the claim level, select EPSDT on the pull-down menu.
3. Under the pull-down menu, **always** select Medicaid.
4. Enter the first Date of Service.
5. From the Benefits Assignment Certification Indicator pull-down menu, select Yes.
6. If COB, click on Other Subscriber Info, and follow instructions in Appendix A.
7. Click on Next Page.

## Claim Line Items

1. If you have another Date of Service (a date that differs from the Date of Service entered on the previous page) enter the Date of Service (mm/dd/ccyy). If the Date of Service is the same as the previous page, leave this space blank.
2. Enter the CDT Procedure/Service Code. Either key in the code or access the Procedure Code List using the pull-down menu.
3. Enter up to 4 Procedure Modifiers.
4. Enter the number of Units being billed.
5. Enter the Charges. If the procedure code was previously entered into the Reference database with the corresponding per unit charge, WINASAP will automatically calculate the charge.
6. If applicable, click on Tooth Information to enter the tooth information related to the line charge. See below for Tooth Information data entry instructions.
7. Click on Add Line Item. Repeat steps above to add additional lines.
8. When all line items have been entered, click on Save.

The claim now appears on the Dental Claim List. Add additional claims using the same instructions.

## Tooth Information

1. Under the Tooth Code pull-down menu, select the code.
2. Under the Tooth Surface Codes pull-down menus, select the codes.
3. When completed, click on OK.

# Creating a Nursing Facility Claim Template (UB-04 Format)

Nursing facility claims use a template to expedite ongoing monthly billing. Once a template is created for each resident, subsequent claims are created by entering the billing month. WINASAP automatically generates a new claim for each resident.

Under the Claims pull-down menu at the top of the screen, select Nursing Facility, then Nursing Facility Template. This opens the Nursing Facility Template List. Click on Add to add a template to the list. Like all WINASAP electronic claims, patient and provider data must be entered prior to creating a template or claim. Since this is a claim template, many of the date fields are left blank, but will be filled automatically when creating claims.

## Template Data

The screenshot shows the 'Nursing Facility Template Data' window. It has three tabs: 'Template Data', 'Template Codes', and 'Template Line Items'. The 'Template Data' tab is active. The form is divided into several sections: 'Patient Information', 'Provider Information', 'Claim Data', and 'Statement Coverage Period'. Numbered callouts (1-10) point to specific fields: 1. Bill Date; 2. Patient ID; 3. Billing Provider; 4. Admission Date; 5. Admission Type; 6. Admission Source; 7. Discharge Status; 8. Statement Coverage Period (From); 9. Type of Bill; 10. Next Page button.

1. Select the Bill Date. Press the F5 key to enter the current date.
- \* Claim Status reads as Template.
2. Select the Patient ID from the Patient ID pull-down menu.
3. Select the Provider ID from the Billing Provider pull-down menu.
4. Enter the Admission Date (mm/dd/ccyy).
5. Enter the Admission Type Code. See the UB-04 manual.
6. Enter the Admission Source Code. See the UB-04 manual.
7. Enter the Discharge Status.

8. Enter the Statement Coverage from Date (enter Admission Date mm/dd/ccyy).
9. Enter the Type of Bill.
10. Click on Next Page.

## Template Codes

The screenshot shows the 'Nursing Facility Template Data' window. It has three tabs: 'Template Data', 'Template Codes', and 'Template Line Items'. The 'Template Codes' tab is active. The form is divided into several sections:

- Procedure Codes:** Includes fields for Principal Procedure Code Qualifier (1), Principal Procedure Code (2), Principal Procedure Date (3), and Other Procedure Codes.
- Diagnosis Codes:** Includes fields for Principal Diagnosis Code Qualifier (1), Principal Diagnosis Code (2), Present on Admission Indicator, Admitting Diagnosis Code Qualifier (3), and Admitting Diagnosis Code (4).
- Additional Claim Codes:** Includes Assignment or Plan Participation Code (5), Release of Information Code (6), Delay Reason Code (7), Claim Filing Indicator Code (8), Assignment of Benefits Indicator (9), and ORG Code.
- Buttons:** Patient Reason for Visit Codes, External Cause of Injury Codes, Occurrence Span Codes (9), Occurrence Codes, Value Codes, Condition Codes, Treatment Codes, and Claim Pricing / Repricing Info.
- Additional Claim Information:** Includes Patient Responsibility Amount (10) and buttons for Claim Notes, Billing Notes, Other Subscriber Info, Other Reference Info, Supplemental Info, Contract Info, File Info, and EPSDT Info.
- Navigation:** At the bottom, there are buttons for Next Page (11), Previous Page, Save, and Cancel.

1. Enter the Principal Diagnosis Code Qualifier.
2. Enter the Principal Diagnosis Code. Users will not see the decimal, but it is recognized to follow after the third digit (e.g., 12310 = 123.10).
3. Enter the Admitting Diagnosis Code Qualifier.
4. Enter Admitting Diagnosis Code. Users will not see the decimal, but it is recognized to follow after the third digit (e.g., 12310 = 123.10).
5. If known, select the appropriate Medicare Assignment Code from the pull-down menu. If unknown, select Not Assigned. This is the recommended default. **This is a HIPAA-required field.**
6. Select the Release of Information Code from the pull-down menu.
7. Under Claim Filing Indicator Code, select Medicaid from the pull-down menu.
8. Select an Assignment of Benefits Indicator.
9. Click on the Occurrence Span Codes button to change level of care from 2 (intermediate) to 1 (skilled). See the following page.
10. Enter the personal resources amount in the Patient Responsibility Amount field.
11. Click on Next Page.

## Template Line Items

1. In the Service Line Revenue Code field enter 160. Either key in the amount or access the Revenue Code List using the pull-down menu.
2. In the Unit or Basis for Measurement Code field, select Days from the pull-down menu.
3. Enter the Daily Rate.
4. Click on Save.

There are no required fields on the Claim Home Health Data screen. The claim now appears on the Nursing Facility Template List. Add additional templates using the same instructions.

## Occurrence Codes

The levels of care are Level of Care 1 = Skilled and Level of Care 2 = Intermediate. The default level of care is Level 2 – No action necessary.

To indicate Level of Care 1:

1. Enter 70 in the Code field.
2. Enter the Date.
3. Click on OK.

# Creating a Nursing Home Claim from the Template List

Under the Tools pull-down menu, select Create Nursing Facility Claims.

## Create Nursing Facility Claims

Create Nursing Facility Claims

Payer: 77039 MONTANA DPHHS Date: 11/30/2011

Billing Type: ☒ Monthly ☐ Other

Statement Coverage Period: / (mm/ccyy) 1

Batch Number:

When finished, press F1 or click Build to create claims.

2 Build Cancel

1. Enter month and year (mm/ccyy) in the Statement Coverage Period field.
2. Click on the Build button.

WINASAP generates a claim for each Nursing Facility template for the month entered.

To make changes to claims, open the Nursing Facility Claims List under the Claims pull-down menu. Users select the claim they wish to change, make any changes, and click on Save.



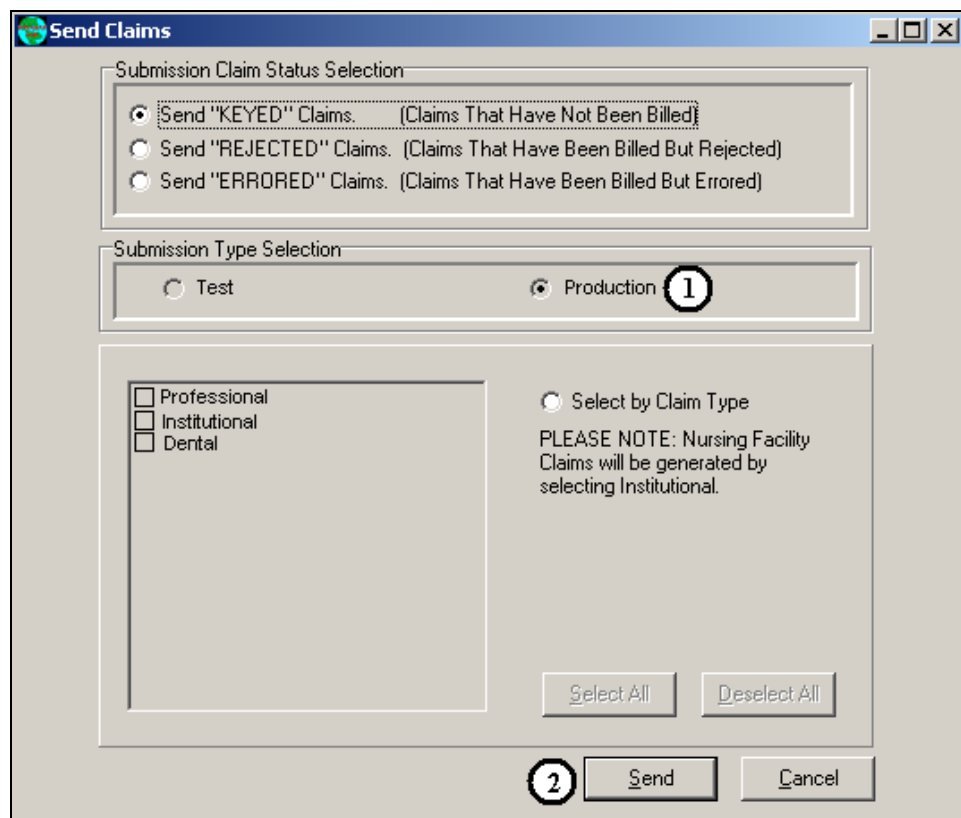
# Submitting Claims

Under the Tools pull-down menu at the top of the screen, select Send Claim File. It is not necessary for users to select by claim type unless they wish to send different claim types in separate batches.

All Claim Lists must be closed.

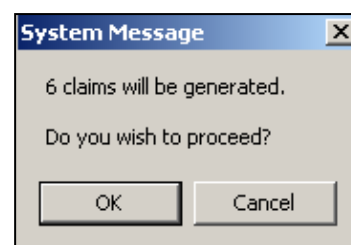
If users want to test the process before submitting claims for processing, they use the Test indicator. **Claims submitted under the Test indicator will not be processed for payment.**

## Send Claims



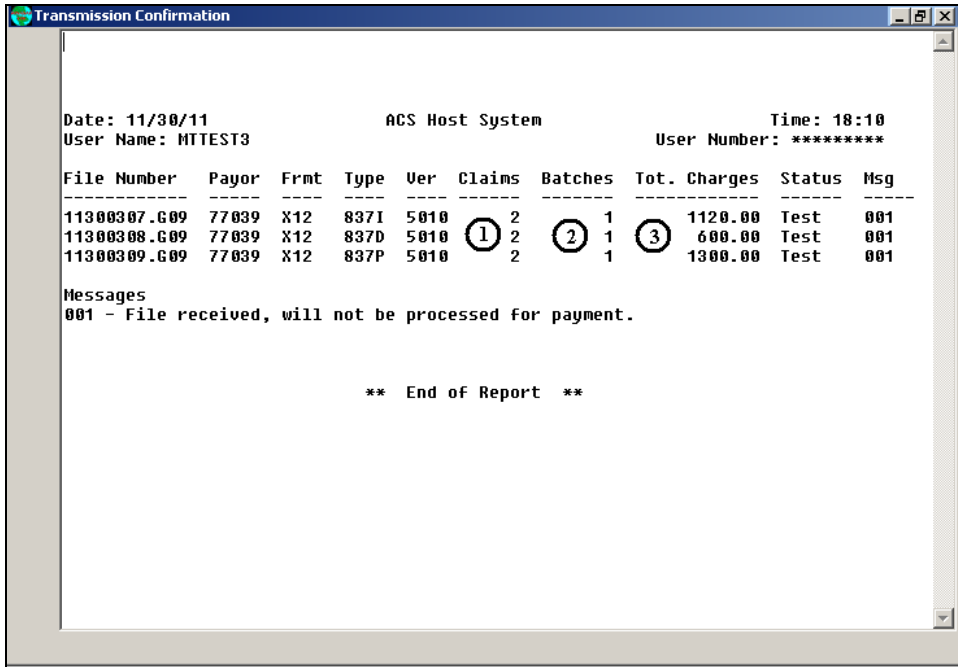
The default is set at Send Keyed Claims. (Claims that have not been billed.)

1. Click on Production. Subsequently each time this screen is opened, it will be set to Production.
2. Click on Send. A System Message appears, indicating how many claims will be generated within this submission or batch. Click on OK to send the claims. WINASAP begins the submission process.



## Transmission Confirmation

Following transmission, users receive a confirmation message similar to the one below.



The screenshot shows a window titled "Transmission Confirmation". Inside, there is a header section with the following information:

Date: 11/30/11                      ACS Host System                      Time: 18:10  
User Name: MTTEST3                      User Number: \*\*\*\*\*

Below the header is a table with the following columns: File Number, Payor, Frnt, Type, Ver, Claims, Batches, Tot. Charges, Status, and Msg.

File Number	Payor	Frnt	Type	Ver	Claims	Batches	Tot. Charges	Status	Msg
11300307.609	77039	X12	837I	5010	2	1	1120.00	Test	001
11300308.609	77039	X12	837D	5010	2	1	600.00	Test	001
11300309.609	77039	X12	837P	5010	2	1	1300.00	Test	001

Below the table, there is a section titled "Messages" with the following text:

001 - File received, will not be processed for payment.

At the bottom of the window, there is a line of text: \*\* End of Report \*\*

The Receipt Complete screen gives the submitter feedback regarding the submission.

1. The number of Claims submitted within the batch.
2. The total number of Batches.
3. The total amount of Charges.

This screen can be printed and saved for verification purposes.

# Submitting Claims through the MATH Web Portal

For a number of reasons (e.g., no internal modem in the computer, having a digital phone line instead of an analog phone line) users may not be able to submit claims through WINASAP using an analog phone or fax line. Instead, they use the Montana Access to Health web portal to submit claims. However, if they do submit claims through the web portal, the Receive Response File and the automatic changing of the status of submitted claims is not available.

Users must register to use the MATH web portal before being able to use it to submit claims. If users do not have access, they should visit the [website](#), and follow the instructions to register for the web portal. Users need to assign their Security Privileges to include Upload Files. This must be selected before uploading the WINASAP claims.

**Security Privileges**

<input type="checkbox"/> Verify Eligibility	<input type="checkbox"/> Check Claim Status	<input type="checkbox"/> View Provider Payment
<input checked="" type="checkbox"/> Upload Files	<input type="checkbox"/> Download Files	<input type="checkbox"/> Office Administrator
<input type="checkbox"/> View e!SOR Reports	<input type="checkbox"/> View Medical History	<input type="checkbox"/> View Electronic Health Record
<input type="checkbox"/> Prescriber Privileges		

The setup of WINASAP5010 is pretty much the same as WINASAP2003.

**Trading Partner Information**

Primary Identification: 7777777 Secondary Identification: 7777777

**Trading Partner Name**

Entity Type: Non-Person  
Organization Name: Provider Name  
Last Name:   
First Name:   
Middle Name:

**Contact Information**

Contact Name:   
Telephone #: (000)000-0000 Ext.   
FAX #: ( ) -   
Email:

**Additional Contact Information**

Contact Name: Additional Contact Name  
Telephone #: (000)000-0000 Ext.   
Fax #: ( ) -   
Email:

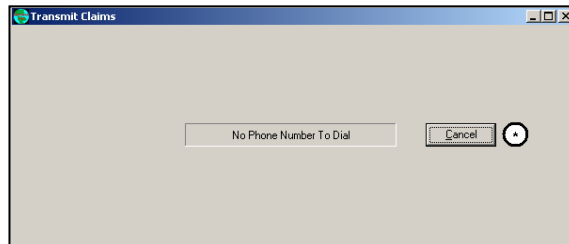
**WINASAP5010 Communications**

Host Telephone #:   
User ID #: MTTEST300  
User Name: MTTEST3

Save Cancel

1. Users enter their Trading Partner information as described on page 6, leave the Host Telephone Number field blank, and click Save.

2. Enter the provider information, the client information, and the diagnosis codes; create the claims, save them as described in this guide, and submit them following the steps on page 29.
3. After doing so, users receive a Transmission Claims message. This indicates that the claim file has been saved to their computer.
4. Click on Cancel.
5. Log into the MATH web portal:  
<https://mtaccesstohealth.acs-shc.com/mt/general/home.do>.



## MATH Home Page

1. Once logged in, select the Upload Files option in the Submissions column.

Montana's Official State Website

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Montana Access to Health Web Portal [Exit](#) | [Help](#)

**HOME INQUIRIES SUBMISSIONS RETRIEVALS MANAGE USERS MY ACCESS**

**Montana Access to Health Web Portal Home Page**

Navigate to any of the functions in the Web portal by clicking the following links or by using the top navigation bar. For information about each function, click the corresponding column header. Click on 'My Profile,' located in the 'My Access' section, to display your current Montana Access to Health Web Portal profile. You will be able to perform only those tasks allowed by the user privileges assigned to you.

**Site Contents**

Inquiries	Submissions	Retrievals	Manage Users	My Access
<a href="#">Eligibility</a>	<a href="#">Upload Files</a>	<a href="#">View/Download Files</a>	<a href="#">Add New User to Organization</a>	<a href="#">My Profile</a>
<a href="#">Claim Status</a>		<a href="#">View eISOR Reports</a>	<a href="#">Add Existing User to Organization</a>	<a href="#">Change Organization</a>
<a href="#">Provider Payment Summary</a>		<a href="#">My Inbox</a>	<a href="#">Update or Remove Users/Reset Password</a>	<a href="#">Change Password</a>
<a href="#">Claims-based Medical History</a>			<a href="#">Manage Submitter IDs</a>	<a href="#">Manage Proxies</a>
<a href="#">Electronic Health Record</a>				
<a href="#">Ask Provider Relations</a>				
<a href="#">Provider Locator</a>				

**ATTENTION PROVIDERS:** The Electronic Health Record link has been added to allow you to view your patients' claims medical history. If you need this access and do not have it, please contact your office administrator. E-prescribing is now available. Please contact your office administrator to add prescribing rights to your user account.

You've logged into the organization displayed under the navigation bar on the right. This organization will be used to determine the Provider Number and Submitter IDs you can use for your transactions (i.e., Inquiries, Submissions and Retrievals). To change this organization, click 'Change Organization' and follow the instructions.

For assistance, visit [Help](#) or contact the Montana Access to Health Web Portal Help Center at 1-800-624-3958.  
 Site last modified: 2011.11.29  
 Build Version: prod-008.22 2011.11.29 - 85

[Go to top of page](#)

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2. Click on the Browse button. This opens a Choose File window where users select their file path.

The screenshot shows the Montana Access to Health Web Portal. The header includes the 'mt.gov' logo, 'Montana's Official State Website', and 'DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES'. A navigation bar contains links: HOME, INQUIRIES, SUBMISSIONS, RETRIEVALS, MANAGE USERS, and MY ACCESS. Below this is a breadcrumb trail: Home > Submissions > Upload Files. The main heading is 'Upload Files'. A note states: 'Only X12 HIPAA compliant files may be uploaded to the system. You cannot upload a file larger than 100MB (megabytes) in size.' Instructions follow: 'Select a Submitter ID, and either enter the path of the file to upload or click 'Browse' to select a file.' The form includes a 'Submitter ID' dropdown menu with '7777777' selected, a 'File Path' text input field, and a 'Browse...' button with a file icon. Below these are 'Upload' and 'Clear Fields' buttons. Footer text includes: 'For assistance, visit [Help](#) or contact the Montana Access to Health Web Portal Help Center at 1-800-624-3958. Site last modified: 2011.11.29 Build Version: prod-008.22 2011.11.29 - 85 Copyright © 2005 ACS. All rights reserved. Go to top of page'.

3. Select the files in the order shown below by double-clicking the files.
  - a. Local Disk (C :)
  - b. Program Files
  - c. ACS
  - d. W5010
  - e. db
  - f. 77039
  - g. 77039.bil. This is where users' claims are saved on their computer. The file path is C:\Program Files\ACS\W5010\db\77039\77039.bil.
4. Click on the Upload button. Users should receive a message stating their file was successfully uploaded.
5. Users must now manually change the status of the claims they have just submitted through the MATH web portal.

## Manually Changing Claim Status

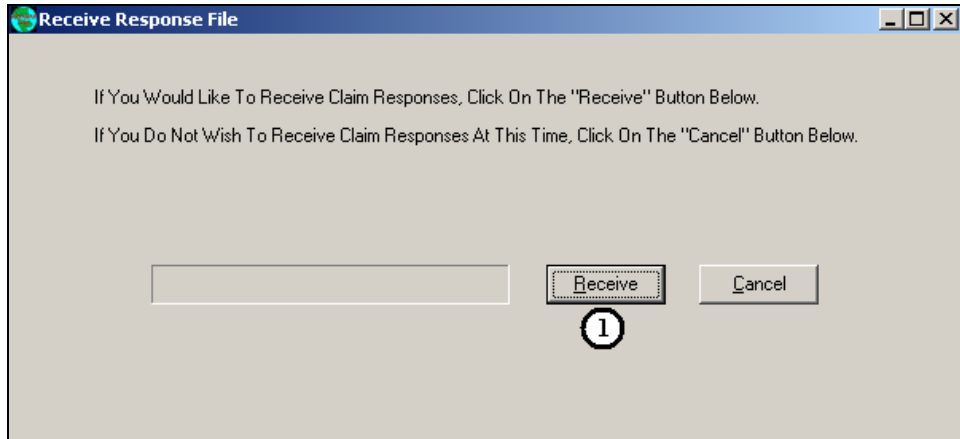
To manually change the status of claims, users must open the Claims List, select the type of claim (professional, institutional, dental, or nursing facility) they want to change, select the specific claim, and open the claim.

The screenshot shows the 'Professional Claim Data' window with the 'Claim Status' dropdown menu open. The menu options are: Keyed, Hold, Billed, Accepted, Rejected, Paid, Denied, and Errored. The 'Hold' option is highlighted. A circled '1' is next to the dropdown. At the bottom right, there is a 'Save' button with a circled '2' next to it. The form includes fields for Patient Information (Patient ID, Last Name, First Name, Patient Account #, Sex, me/Initial), Provider Information (Billing Provider, Pay-to-Address, Rendering Provider, Referring Provider 1, Referring Provider 2, Supervising Provider, Pay-to-Plan), and Claim Data (Health Care Diagnosis Codes, Anesthesia Related Procedure, Condition Information, Place of Service, Claim Frequency).

1. Click on the pull-down menu next to Claim Status and select Hold.
2. Click on Save. This prevents the claim from being resubmitted with the next batch of claims if users choose to keep their submitted claims in the Claims List.

# Running a Receive Response File

Under the Tools pull-down menu, select Receive Response File.



1. Click on Receive.
2. WINASAP connects to the host and updates the status of sent claims on Claims Lists. Unsent claims are in Keyed status. Sent claims default to Billed status.

Following the Receive Response File, sent claims are either accepted or rejected. If a claim is marked as rejected, contact EDI Gateway at (800) 987-6719 or Provider Relations at (800) 624-3958 for an explanation and for steps that are needed to correct rejected claims.

# Reports, Backing up a Database, and Other Features

Under the Tools pull-down menu, select Reports. WINASAP can generate a variety of reports. Select the report type and criteria and click on Run in the lower right of the screen. Other items of interest under the Tools menu are:

1. Back-Up Database
  - a. By backing up a database, users ensure that data can be recalled in the event of data loss.
  - b. A backup is recommended on a regular basis. Data can be backed up to the WINASAP database, folders, desktop, a jump drive, or CD.
  - c. To recall a backup, use the Restore Database option under the Tools menu.
2. Purge Claims
  - a. Purge claims to remove them from the Claim List.
  - b. Once removed, purged claims can be found in the WINASAP Database File.
3. Security
  - a. Passwords may be changed, and users can be added through the Security option.
4. To view the version of WINASAP being used, access the Help Menu and select About. A screen appears indicating the version being used (e.g., Version 5.15).
5. Database Repair Tool
  - a. This item can be used to troubleshoot minor glitches or errors that are experienced within the software. Once a Database Repair Tool is complete, WINASAP closes.



# Troubleshooting Submission Errors, FAQs, and Helpful Hints

## Troubleshooting Submission Errors

### 1. Modem Not Accessible

- a. WINASAP is direct submission software; therefore, a direct submission method must be reflected.
- b. The system that best reflects that is a dial-up modem and phone line.
- c. Many computers have internal modems and can simply have a phone or fax line plugged directly into the computer to resemble direct submission compliance.
- d. To find an active modem on the computer, access the Control Panel or contact technical support.
- e. During submission we recommended that users are disconnected from the Internet, other than through the dial-up connection.

### 2. User Not Approved for Payer/Format/Type

- a. This error occurs on the Receipt Complete screen.
- b. To resolve this issue, contact EDI Support at (800) 987-6719.

## Frequently Asked Questions (FAQs)

### 1. I just had that screen up, and it disappeared!

In WINASAP multiple screens can get concealed behind one another. Try minimizing the open screens to see if there is something displayed behind it. The minimized screens can always be maximized again.

### 2. When will WINASAP be able to submit over the regular Internet?

WINASAP is free billing software. At this time, there are no plans to upgrade to submission through the regular Internet; it remains dial-up only.

### 3. How will I know what the latest version of WINASAP is?

The latest version of WINASAP is available at [www.acs-gcro.com](http://www.acs-gcro.com).

### 4. How come my claim denied; the Receive Response File said Accepted?

When claims are submitted electronically, they are screened for validity of data and HIPAA compliancy. If the submitted claims fail to meet these criteria, they are rejected from processing. If all criteria are met, the electronic claim gets Accepted; however, this Accepted status means that the claim was received by Medicaid for processing. A claim can still deny for many reasons.

### 5. I am trying to submit my claims, but the item is gray and won't let me select it.

You need to be closed out of all data entry screens when submitting claims. Before submitting claims, close all screens so only the gray WINASAP screen shows.

**6. I am trying to open WINASAP, and it won't let me enter. There is no user ID that comes up.**

WINASAP can experience this error particularly if Windows Vista is being run. The user ID at the log in screen needs to read ADMIN (unless changed or modified under Security). To allow this, right-click on the WINASAP icon and select Run as Administrator. This allows access to the program.

**7. I tried to enter a patient or provider ID, and I'm getting an error saying it isn't the right length.**

You can manually modify the length allowed for the patient or provider data ID. Under File/Open Payer/Show Payer Edits, there is an option to modify the length.

## Helpful Hints

1. When downloading WINASAP, save it to the computer Desktop, then install the program from there. The installation software looks like a red box. Once installed, the actual WINASAP application resembles a globe with red writing on it.
2. It always helps to back up data on a jump drive to store at an alternative location to have if something happens to the computer on which WINASAP is installed.
3. When frequently submitting claims for the same patient with the same codes, use the Copy feature in the Claim List. This copies the claim and allows updates to it. This saves data entry time because updates can be done to the data that changes (e.g., bill dates, services dates) and the rest is already entered.
4. Use the Receive Response File. It is beneficial to know if claims are rejecting on the electronic submission. If there is nothing coming through on the Remittance Advice, this is an indicator of claims rejecting.
5. If users are running (or attempting to run) WINASAP on a Mac, the program does not work to its full extent. WINASAP has sometimes run successfully on a Mac, but overall its functionality does not operate well.
6. Ensure the right payer is selected before submitting claims. The payer is indicated in the blue bar at the top of the screen and reads Montana DPHHS.
7. If users wish to have a disc sent to their location instead of downloading WINASAP from the website, they should call Provider Relations at (800) 624-3958 or the EDI Helpline at (800) 987-6719 to have a disc mailed.
8. Once WINASAP is successfully installed, delete the installation box to prevent from installing the software again. **If the database is not backed up to an external location (disc, zip drive, jump drive) and WINASAP is installed over the top, all previously entered data will be lost.**
9. When restoring a database, keep in mind that it will overwrite current data. There is no function to take parts of multiple databases and collaborate.

## Appendix A – Indicating TPL Payments in a WINASAP Claim

If users need to indicate that Medicaid is not primary on a patient, access the patient data through Reference/Patient. Once the Patient List comes up, users can either double-click the patient to access or select the Change tab.

For WINASAP professional claims in which Medicaid pays secondary or tertiary to another insurer (TPL), providers should follow these instructions to enter the TPL paid amount and other TPL information.

Claims indicating a TPL payment (not including Medicare) do not require attached paper documentation. However, an attachment is required if the TPL denies payment for noncovered services, exceeded benefits, etc.

The numbers on the screen shot below indicate the fields required to indicate Medicaid as secondary or tertiary.

The screenshot shows the 'Patient Data' window with the 'Insured's Data' tab selected. The window is divided into three main sections: 'Insured's Information', 'Property and Casualty Information', and 'Payer Information'. Numbered callouts indicate the following fields:

- 1:** 'Patient Relationship to Insured' dropdown menu in the 'Insured's Information' section.
- 2:** 'Payer Responsibility Sequence Code' dropdown menu in the 'Payer Information' section, currently set to 'Secondary'.
- 3:** 'Save' button at the bottom right of the window.

1. In the Patient Reference Database, on the Insured's Data tab, under Patient Relationship to Insured, be sure that Self is entered.
2. Under Payer Responsibility Sequence Code, select Medicaid as Secondary (or Tertiary, if applicable).
3. Click on Save to exit the screen.

On the Professional Claim Data screen, Claim Information tab, click on Other Subscriber Info.

The screenshot shows a software window titled "Professional Claim Data" with four tabs: "Claim Data", "Claim Codes", "Claim Information", and "Claim Line Items". The "Claim Information" tab is selected. Inside the window, there is a section labeled "Claim Information" which contains a sub-section titled "Additional Claim Level Information". This sub-section has a circular arrow icon at the top right. Below the icon, there are two columns of buttons. The left column contains: "Ambulance Transport Info", "Claim Note", "Claim Price/Reprice Information", "Contract Info", "EPSDT Info", "File Info", and "Miscellaneous Dates". The right column contains: "Other Subscriber Info", "Spinal Manipulation Info", "Supplemental Info", "Related Causes Info", "Service Facility Info", and "Vision Info". At the bottom of the window, there are four buttons: "Next Page", "Previous Page", "Save", and "Cancel".

Other subscriber information allows the entry of many different aspects of third party payers, including Medicare.

- For Professional claims, Other Subscriber Info is located on the Claim Information tab.
- For Institutional claims, Other Subscriber Info is located on the Claim Codes tab in the bottom row of tabs.
- For Dental claims, Other Subscriber Info is located on the Claim Information tab near the bottom.
- For Nursing Facility claims, Other Subscriber Info is located on the Claim Codes tab in the bottom row of tabs.

## Other Subscriber Page 1

Complete the following fields on page 1 of this screen.

Other Subscriber Information

Other Subscriber Page 1 | Other Subscriber Page 2

1

Insured's Name

Patient Relationship To Insured:  Entity Type:

Organization Name:

Last Name:  First Name:  Middle Name/Initial:  Suffix:

Insured's Address

Address:  Address (con't):

City:  State:

Zip Code:

Insured's Identification

Insured's Primary ID Type:  Insured's Primary ID:  Secondary Identification

Delete First Previous Next Last

6 OK Cancel

1. Patient Relationship to Insured.
2. Entity Type.
3. Last Name and First Name.
4. Insured's Primary ID Type.
5. Insured's Primary ID.
6. Click on OK or the Other Subscriber Page 2 tab at the top to move to the second page.

## Other Subscriber Page 2

Complete the following fields on page 2 of this screen.

1. Group or Policy Number.
2. Group or Plan Name.
3. Insurance Type Code.
4. Claim Filing Indicator.
5. Release of Information Code.
6. Patient Signature Source Code.
7. Payer Name.
8. Payer Responsibility Sequence Code (enter Primary).
9. Payer Primary ID Type.
10. Payer Primary ID.
11. Claim Check or Remittance Date.
12. Click on COB Amounts.

## COB Information

1. Enter the Paid Amount (TPL payment). Be sure to indicate payment with a 2-digit decimal to ensure the amount comes across correctly (e.g., 100.00 not 100).
2. Click on OK. Repeat the process for other TPL payments on the claim.

## Appendix B – Indicating Medicare Part B for a Professional Claim

Follow the same procedures to indicate in the patient's data that Medicaid is either Secondary or Tertiary. (See Running a Response File instructions on page 35.)

When entering the Professional Claim, on the Claim Codes tab, enter Assigned for the Medicare Assignment Code.

The screenshot shows the 'Professional Claim Data' window with the 'Claim Codes' tab selected. The 'Claim Codes' section contains several dropdown menus: 'Medicare Assignment Code' is set to 'Assigned' (marked with a circled '1'), 'Release of Information Code' is 'Informed Consent to Release Medical Information for Conditions or Diagnosis Regulated by Federal Statutes', 'Patient Signature Source Code' is 'Signature generated by provider because the patient was not physically present for Services', 'Special Program Indicator Code' is empty, 'Delay Reason Code' is empty, and 'Claim Filing Indicator' is 'Medicaid'. The 'Claim Indicators' section has 'Homebound Indicator' as 'No' and 'Benefits Assignment Certification Indicator' as 'NA'. The 'Claim Amounts' section has 'Patient Amount Paid' as an empty field. The 'Claim Numbers' section has 'Mammogram Certification Number', 'Medical Record Number', and 'CLIA Number' as empty fields, and 'Referral Number', 'Prior Authorization', and 'Other Claim Level Numbers' as empty fields. At the bottom are buttons for 'Next Page', 'Previous Page', 'Save', and 'Cancel'.

Proceed to follow normal claim billing procedures.

## Other Subscriber Page 1

On the third page of data within a Professional Claim, select Other Subscriber Information.

Complete the following fields on page 1 of this screen.

The screenshot shows a software window titled "Other Subscriber Information". At the top, there are two tabs: "Other Subscriber Page 1" and "Other Subscriber Page 2", with the second tab highlighted and numbered 6. The form is divided into three main sections: "Insured's Name", "Insured's Address", and "Insured's Identification".

- Insured's Name:** This section contains several fields. A dropdown menu for "Patient Relationship To Insured:" is numbered 1. An "Entity Type:" dropdown is numbered 2. Below these are fields for "Organization Name:", "Last Name:" (numbered 3), "First Name:" (numbered 3), "Middle Name/Initial:" (numbered 3), and "Suffix:". A small box in the top right corner of this section is numbered 1.
- Insured's Address:** This section includes fields for "Address:", "Address (cont):", "City:", "State:" (a dropdown), and "Zip Code:".
- Insured's Identification:** This section has a dropdown for "Insured's Primary ID Type:" (numbered 4), a text field for "Insured's Primary ID:" (numbered 5), and a button labeled "Secondary Identification".

At the bottom of the form, there are navigation buttons: "Delete", "First", "Previous", "Next", and "Last". Below these are "OK" and "Cancel" buttons.

1. Patient Relationship to Insured: Self.
2. Entity Type: Person.
3. Last Name and First Name.
4. Insured's Primary ID Type: Select Member Identification Number. Insured's Address is not required.
5. Insured's Primary ID: Enter patient's Medicare ID Number.
6. Click on the Other Subscriber Page 2 tab at top to move to the second page.



## Other Subscriber Page 2

Complete the following fields on page 2 of this screen.

**Other Subscriber Information**

Other Subscriber Page 1 | Other Subscriber Page 2

**Insurance Information**

Group or Policy #: 1 Group or Plan Name: 2

Insurance Type Code: 3 Claim Filing Indicator: 4

Release of Information Code: 5

Patient Signature Source Code: 6

Benefits Assignment Certification Indicator: 12 COB Amounts Outpatient Adjudication Info

**Other Payer Information**

Payer Name: 7 Payer Responsibility Sequence Code: 8

Payer Primary ID Type: 9 Payer Primary ID: 10

Payer Address: Payer Address (cont):

Payer City: Payer State: Payer Zip Code:

Claim Check or Remittance Date: 11

Claim Adjustment Indicator: ☐ Yes Claim Control Number:

Secondary ID Information Prior Auth/ Referral Number Billing Provider ID Referring Provider ID Supervising Provider ID

Service Facility ID Adjustment Info Rendering Provider ID

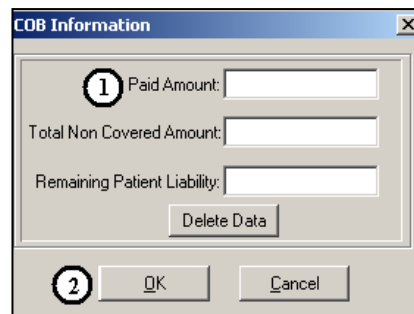
Delete First Previous Next Last

OK Cancel

1. Group or Policy Number.
2. Group or Plan Name.
3. Insurance Type Code: Medicare Part B.
4. Claim Filing Indicator: Medicare Part B.
5. Release of Information Code: Select the first option.
6. Patient Signature Source Code: Select the first option.
7. Payer Name: Noridian Medicare.
8. Payer Responsibility Sequence Code: Enter Primary.
9. Payer Primary ID Type.
10. Payer Primary ID: Enter MCARE PART B for Noridian Medicare.
11. Claim Adjudication Date: The date the claim processed in Medicare.
12. Click on COB Amounts.

## COB Information

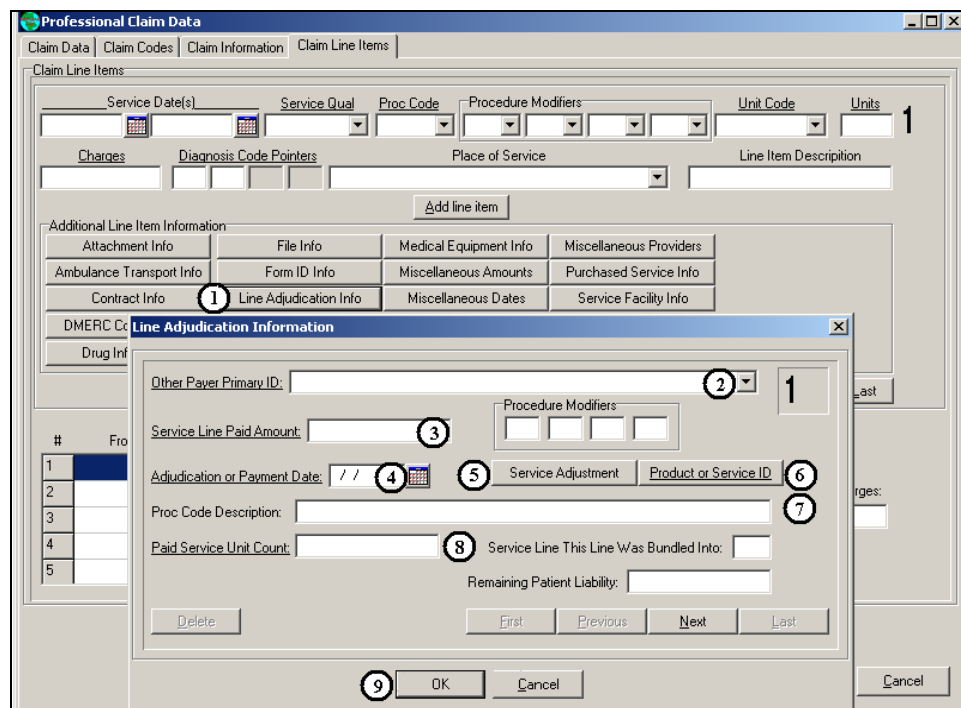
1. Enter the paid amount to indicate the total amount paid by Medicare on this claim. Indicate the payment with a 2-digit decimal to ensure the correct amount comes across (100.00 not 100).
2. Click on OK. Repeat this process to add any additional payments.



The COB Information dialog box contains the following fields and controls:

- 1** Paid Amount: [Text Field]
- Total Non Covered Amount: [Text Field]
- Remaining Patient Liability: [Text Field]
- Delete Data: [Button]
- 2** OK: [Button]
- Cancel: [Button]

## Claim Line Items



The Professional Claim Data - Claim Line Items dialog box is shown with the Line Adjudication Information sub-dialog box open. The sub-dialog box contains the following fields and controls:

- Other Payer Primary ID: [Pull-down Menu] **2**
- Service Line Paid Amount: [Text Field] **3**
- Adjudication or Payment Date: [Date Picker] **4**
- Service Adjustment: [Pull-down Menu] **5**
- Product or Service ID: [Pull-down Menu] **6**
- Proc Code Description: [Text Field] **7**
- Paid Service Unit Count: [Text Field] **8**
- Service Line This Line Was Bundled Into: [Text Field]
- Remaining Patient Liability: [Text Field]
- Delete: [Button]
- First: [Button]
- Previous: [Button]
- Next: [Button]
- Last: [Button]
- 9** OK: [Button]
- Cancel: [Button]

1. Under Additional Line Item Information, select the Line Adjudication Info button.
2. For Other Payer Primary ID, select the pull-down menu, and indicate the same Payer Primary ID entered previously (MCARE PART B).
3. Enter the paid amount in the Service Line Paid Amount field.
4. In the Adjudication or Payment Date field, enter the adjudication date of the claim.
5. Select the Service Adjustment button.
  - a. Group Code – Select the appropriate code identifying the general category from the pull-down list.
  - b. Reason Code – Select either 1 Deductible Amount or 2 Coinsurance Amount from the pull-down list.
  - c. Adjusted Amount – Enter the amount of the deductible or coinsurance.

6. Select Product or Service ID.
  - a. Identification Type – **Always** select **HCPCS** from the pull-down list.
  - b. Identification Number – Enter the appropriate procedure code from the corresponding line item.
7. In the Proc Code Description field, enter the procedure code description.
8. In the Paid Service Unit Count field, enter the number of paid units.
9. Click on OK.

If there are additional service dates that need to be billed, click the Add Line Item button and repeat the steps for each additional line items.

## Appendix C – Paperwork Attachments / Blanket Denial Letters

For WINASAP claims in which a provider must indicate that a separate paperwork attachment has been sent, or to reference a blanket denial letter on file in the TPL Unit, click on the Supplemental Info button.

The screenshot shows the 'Professional Claim Data' application window. The 'Claim Information' tab is selected. Inside the window, there is a section titled 'Additional Claim Level Information' which contains a grid of buttons. A red circle with the number '1' highlights the 'Supplemental Info' button. At the bottom of the window are buttons for 'Next Page', 'Previous Page', 'Save', and 'Cancel'.

Additional Claim Level Information	
Ambulance Transport Info	Other Subscriber Info
Claim Note	Spinal Manipulation Info
Claim Price/Reprice Information	Supplemental Info <span style="border: 1px solid red; border-radius: 50%; padding: 2px;">1</span>
Contract Info	Related Causes Info
EPSDT Info	Service Facility Info
File Info	Vision Info
Miscellaneous Dates	

Next Page Previous Page Save Cancel

## Supplemental Information

The black arrows on the screen images indicate required fields.

The screenshot shows a window titled "Supplemental Information". Inside, there are three columns: "Report Code", "Transmission Code", and "Identification Code". Below these columns are 10 rows of input fields. The first row's fields are circled with numbers 1, 2, and 3. A "Delete Data" button is located below the input fields. At the bottom of the window are "OK" and "Cancel" buttons, with the "OK" button circled with the number 4.

1. Under the Report Code pull-down menu, select the type of attachment (e.g., EOB). If the exact definition is not listed, select Support Data for Claim.
2. Under the Transmission Code pull-down menu, select the appropriate code (e.g., By Mail for attachments sent by mail with the Paperwork Attachment Cover Sheet; Electronically Only to reference a Blanket Denial Letter on file in the TPL Unit).
3. In the Identification Code field, enter the Attachment Control Number for attachments sent by mail with the Paperwork Attachment Cover Sheet. This number consists of the provider's ID number, client's ID number, and date of service (mmddccyy) each separated by a hyphen. This number must match the Paperwork Attachment Control Number entered on the Paperwork Attachment Cover Sheet.

For claims referencing a blanket denial letter on file in the TPL Unit, enter the reference number assigned by the TPL Unit. The format of this number is TPL + Client ID Number + Carrier Code with no hyphens between the three elements.

4. When completed, click OK.